STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366238	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwood Towers Post-Acute	1500 Sherman Avenue Cincinnati, OH 45212

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident and staff interview, hospice staff interview, review of the hospice record, review of the controlled drug receipt/record/disposition form, review of the text message correspondence, and policy review, the facility failed to ensure a resident with chronic pain syndrome received as needed medication for breakthrough pain. This resulted in Actual Harm, when staff failed to ensure Resident #08 received as needed (PRN) pain medication when she reported severe pain. This affected one (#08) of three residents reviewed for pain. The census was 110. Findings include: Medical record review for Resident #08 revealed an admission date of 12/14/24. Diagnoses included chronic pain syndrome, malignant neoplasm of the larynx, anxiety, depression, posttraumatic stress disorder, osteomyelitis of the back, fibromyalgia, and bowel rupture with colostomy. Resident #08 was diagnosed on [DATE] with cT3NO (a cancer tumor that has spread into the outermost layer but has not spread to the lymph nodes) head and neck cancer. On 09/17/25 hospice services began. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #08 was cognitively intact. The resident was independent for most activities of daily living, including tracheal stoma and colostomy care. Review of the pain plan of care for Resident #08 revealed to administer pain medications as ordered, be aware of resident's diagnoses to ensure pain medication had been ordered and observe for pain every shift. The goal was for Resident #08 not to experience pain during stay in the facility. Review of the physician orders dated 09/30/25 revealed oxycodone (opioid medication for moderate to severe pain) hydrochloride (HCl) oral tablet 10 milligrams (mg), give two tablets by mouth every three hours as needed (PRN) for pain.ˆReview of the Medication Administration Record (MAR) from 12/01/25 through 12/02/25 revealed the order was documented as given to the resident on 12/01/25 at 10:01 A.M., then again on 12/02/25 at 10:32 A.M., 8:53 P.M. and 11:59 P.M. Review of the progress notes dated 12/01/25 through 12/02/25 revealed the ordered oxycodone was administered at 10:01 A.M. on 12/01/25 and on 12/02/25 at 10:32 A.M, 8:53 P.M. and 11:59 P.M. There was no documentation on 12/01/25 revealing Resident #08 requested pain medication multiple times beginning at 1:30 P.M. through 9:30 A.M. on 12/02/25. Additionally, there was no documentation the hospice nurse was notified the pain medication was not available for administration. Review of the controlled drug receipt/record/disposition form dated 11/24/25 revealed on 12/01/25 at 12:00 A.M., two pills were signed as given leaving two pills remaining. On 12/01/25 at 10:00 A.M., two pills were signed as given and left a remaining count of zero oxycodone pills. On 12/02/25, 15 pills of oxycodone were checked in on the count sheet by Licensed Practical Nurse (LPN) #244, and two pills were documented as given on 12/02/25 at 10:32 A.M.ˆReview of the hospice note dated (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0697 Level of Harm - Actual harm Residents Affected - Few	12/01/25 revealed Resident #08 was out of oxycodone, and it was reordered and will receive tonight. Interview and observation with Resident #08 on 12/02/25 at 9:52 A.M. revealed her pain level was not controlled. She stated she had asked the nurse for the PRN oxycodone more than once and was told it was not available. Resident #08 tearfully reported it had been almost 24 hours since her last PRN pain medication dose was administered, her pain was at level nine out of 10 on a numeric pain scale of one to 10 with 10 being the worst pain. Resident #08 was told the medication was still not available, and she was unclear if it was the fault of the hospice or the pharmacy. She stated she had pain in her neck, hip, back and wrist and had reduced ability to move and perform activities of daily living. Interview and observation on 12/03/25 at 12:26 P.M. with LPN #273 revealed it was reported to her that the facility was out of Resident #08's PRN oxycodone since the morning of 12/01/25 so some was ordered. She verified there was a bottle of oxycodone from the local pharmacy filled on 12/02/25 for 12 tablets with only 10 tablets left in the bottle and assumed it was an emergent order. A telephone interview on 12/03/25 at 2:44 P.M. with the hospice LPN #915 revealed Resident #08 texted on 12/01/25 at 1:27 P.M. to inform her the pain medication was out. The hospice LPN #915's review of the oxycodone medication revealed the active prescription still had 266 tablets available and she was uncertain why they were not there. Resident #08 texted her again on 12/02/25 at 9:13 A.M. reporting she still was in pain and had not received any administrations of oxycodone since the previous morning and was told the facility received the wrong medications from the pharmacy. The hospice LPN #915 further reported she was informed the facility was trying to rectify an automatic discontinue on this order for Resident #08. The hospice LPN #915 obtained an emergency order for twelve oxycodone tablets, called the order into the local pharmacy, picked up the medication and brought it to the facility for administration at 10:32 A.M. on 12/02/25. LPN #915 reported a note from a hospice Registered Nurse (RN) #910 dated 12/01/25 revealed the facility was out of Resident #08's oxycodone. It was standard procedure for the facility to inform the hospice if a refill was needed. A follow-up telephone interview on 12/10/25 at 1:31 P.M. with hospice LPN #915 revealed she had been notified via text message on 12/01/25 at 1:27 P.M., that Resident #08 was out of her breakthrough pain medication. She said she reviewed the orders for her oxycodone, and they were active and had remaining refills. She said the facility was having some issues with the pharmacy and keeping the medication refilled. LPN #915 said they had the same issue on 11/25/25 when Resident #08 ran out of pain medication. LPN #915 said she received another text message the morning of 12/02/25 at 9:13 A.M., that the wrong medication was sent and Resident #08 was still in pain. LPN #915 called for an emergency order for 12 tablets of oxycodone medication, picked it up from a local pharmacy, and brought it to the facility for administration at 10:32 A.M., on 12/02/25. Interview on 12/11/25 at 9:44 A.M. with LPN #244 verified she only administered one dose of Oxycodone 10 milligrams at 10:01 A.M. on 12/01/25 to Resident #08 because the resident had no more Oxycodone available. LPN #244 said she told Resident #08 she had no more Oxycodone available. When LPN #244 was asked why she didn't request access to the Omni-Fill emergency distribution system, she replied by saying the resident had not requested any more pain medication that day. LPN #244 verified the Oxycodone order refill did not arrive until 12/02/25. Review of the five screen shots of a text message correspondence between Resident #08 and the hospice LPN #915 on 12/01/25 at 1:27 P.M., revealed the facility notified Resident #08 they were out of her PRN oxycodone, and again on 12/02/25 at 9:13 A.M. Resident #08 sent a text message reported, per the facility, pharmacy received the wrong medication. The hospice LPN #915 replied she was on her way to the facility. Review of the policy titled Administering Medications dated April 2019, revealed medication administration times are determined by resident need and benefit, not staff convenience, and include enhancing optimal therapeutic effect of the medication, consistent with his (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interviews, observation, and review of facility policy, the facility failed to provide information on the grievance process and how to file a grievance. This affected three (Residents #37, #66 and #106) of three residents reviewed on how to file a grievance and had the potential to affect all residents residing in the facility. The facility census was 111. Based on record review, staff and resident interview, observation, and policy review, the facility failed to provide information on the grievance process and how to file a grievance. This affected three (Residents #37, #66 and #106) of three residents reviewed on how to file a grievance. This had the potential to affect all residents residing in the facility. The facility census was 111. Findings include: 1. Review of medical record and quarterly Minimum Data Set (MDS) dated [DATE] for Resident #37 revealed he was admitted to facility on 07/17/25 and revealed resident to be cognitively intact. Resident #37 currently serves as the presiding president of the facility's Resident Council. Interview on 12/09/25 at 4:20 P.M. with Resident #37 revealed Resident #37 was unaware of the right to file a grievance and how the process was accomplished. Resident #37 denied ever having the grievance process explained to him individually or during a resident council meeting. 2. Review of medical record and quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #66 was admitted on [DATE], with moderate cognitive impairment. Interview on 12/10/25 at 9:40 A.M. with Resident #66 revealed Resident #66 was unaware of how to lodge a grievance and admitted he was unaware of a process for filing a grievance. Resident #66 revealed he attended most resident council meetings but cannot remember anyone ever talking about the grievance process. 3. Review of medical record and quarterly MDS dated [DATE] for Resident #106 revealed he was admitted on [DATE] and is cognitively intact. Interview on 12/10/25 at 9:52 A.M. with Resident #106 revealed Resident #106 was aware of what a grievance was but was unaware the facility had a structured program for filing and resolution of grievances. Resident #66 revealed he had attended resident council meetings and had never heard anyone talk about the grievance process. Interview on 12/10/25 at 9:37 A.M. with the Administrator revealed the Administrator had not been involved in a formal grievance since coming to the facility. The Administrator was able to provide a facility policy on Grievances and the names of the three members of the grievance committee (Resident #66, Social Services Assistant #232 and Nurse Practitioner #996). Observation during a tour of the facility on 12/10/25 at 3:32 P.M. with Assistant Director of Nursing #224 revealed no posted information on the grievance process or how to file a grievance. Interview on 12/10/25 at 3:32 P.M. with Assistant Director of Nursing (ADON) #224 verified no knowledge of how the grievance process worked. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the policy titled, Grievances/Complaints, Filing, undated, revealed residents and their representatives have the right to file grievances either orally or in writing, to facility staff or to the agency designated to hear grievances (e.g. the State Ombudsman). Review of the policy titled, Resident Rights, revised August 2009, revealed the resident had the right to voice grievances and have the facility respond to those grievances, and the facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff and resident interviews, observations, and policy review, the facility failed to ensure the residents were made aware of what they were going to be served for meals. This had the potential to affect 108 of the 111 residents in the facility who received food from the kitchen. The facility identified three residents (#9, #17 and #89) who did not receive food from the kitchen. The facility census was 111. Based on review of the medical record, staff and resident interviews, observations, and policy review, the facility failed to ensure the residents were made aware of what they were going to be served for meals. This affected three (#28, #93, and #117) out of five residents reviewed for food and nutrition. This had the potential to affect 108 out of the 111 residents in the facility who received food from the kitchen. The facility identified three residents (#9, #17 and #89) who did not receive food from the kitchen. The facility census was 111. Findings included: 1.Medical record review for Resident #28 revealed an admission date of 04/16/25. Medical diagnoses included traumatic spinal cord injury, paraplegic, peripheral vascular disease, neurogenic bladder, and viral hepatitis. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #28 was cognitively intact. Her functional status was supervision or touching assistance for eating. Interview and observation on 12/01/25 at 12:03 P.M. Resident #28 received her tray while surveyor was in the room and stated she didn't know what was being served for lunch. She revealed there wasn't anything handed out to the residents and the menu the facility posted was out of date. 2.Review of the medical record for Resident #93 revealed an admission date of 04/14/22. Medical diagnoses included cerebral palsy, cerebrovascular attack, and diabetes. Review of the quarterly MDS dated [DATE] revealed Resident #93 was moderately cognitively impaired. Her functional status was set up to clean-up assistance for eating. Interview with Resident #93 on 12/01/25 at 12:11 P.M. revealed she didn't like her meal, had no idea what was being served for meals and had not received a menu or did she know where to look for one. 3.Review of the medical record revealed Resident #117 was admitted to the facility on [DATE] with diagnoses of sepsis, alcoholic liver disease and pulmonary embolism. Review of the MDS admission assessment dated [DATE] revealed Resident #117 had intact cognition and was always continent of bowel and bladder. Section GG was not completed. Interview with Resident #117 on 12/01/25 at 12:12 P.M. revealed he didn't like the turkey he was served for lunch. He revealed he didn't know if he could get something else, didn't know where the menu was posted and didn't know what he was going to be served for lunch. Observation of the Certified Nursing Aide (CNA) #337 on 12/02/25 from 12:12 P.M. to 12:16 P.M. revealed she was not letting the residents know what was for lunch and dinner and asked if they wanted an alternate for those meals. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview at the same time on 12/01/25 at 12:16 P.M. with Certified Nursing Aide (CNA) #337 revealed the residents received a menu at the beginning of the week and activities usually passed the menus out to the residents. The CNA took the surveyor to where the menu was posted by the dining room and there were four months of menus with four weeks on each page and none of them were dated. The aide revealed if the menu wasn't dated the only way she would know what was served was on the day the meal was served, and she looked on this spreadsheet to determine what was going to be at that moment since it wasn't dated. She confirmed she didn't pass out any menus to the resident and the menus posted would be difficult for the residents to determine what was being served for their meals. She confirmed she didn't inform the residents what was for lunch and dinner since she didn't know herself with what was posted on the wall. Observation of the menu board in front of the dining room on 12/10/25 at 12:24 P.M. revealed there wasn't a menu in there for the three meals being served on 12/01/25. Interview with Dietary Manager (DM) #272 on 12/02/25 at 12:25 P.M. revealed there was a four-week cycle posted on the units for the meals. He revealed the aides were to pass out the menus and they were also placed in the admission packet for the residents as well. He reported the dietary staff encourage the aides when they take the residents their breakfast trays to let the residents know what was for lunch and dinner. He reported if someone wasn't cognitively intact or was bed bound, he didn't know what they would do about the menus. He reported menus were hanging on boards in the hallways he said residents just figure out what they are having, or they can ask a staff person. If staff person does not know what week it is, they can just call the kitchen to find out. it's not that hard. Review of the policy titled, Menus, undated, revealed menus for regular and therapeutic diets are written at least two (2) weeks in advance and are dated and posted in the kitchen every Monday for the following week and Friday for the upcoming weekend. Copies of menus are posted by Dietary Manager or on-duty cook, in at least two (2) resident areas, in positions and in print large enough for residents to read them.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and policy review, the facility failed to ensure food was stored in a manner to prevent the potential spread of foodborne illness. This had the potential to affect 108 out of 111 residents in the facility who received food from the kitchen. The facility identified three residents (#9, #17 and #89) who did not receive food from the kitchen. The facility census was 111. Findings include: Initial tour of kitchen on 12/01/25 at 8:30 A.M. with Dietary Supervisor (DS) #272 revealed several issues with food storage in the dry storage area, the walk-in refrigerator, the walk-in freezer as well as the first floor, the second floor, and the third floor kitchenette refrigerators. Observation on 12/01/25 at 8:43 A.M. of dry storage area with DS #272 revealed a bag of undated and open to air flour tortillas and undated pasta. DS #272 confirmed the open to air and undated tortillas and the undated pasta. Observation on 12/01/25 at 9:02 A.M. of the walk-in refrigerator with DS #272 revealed three individual serving sized yogurts with expiration dates of 11/03/25. DS #272 confirmed, removed and threw the expired yogurts away. Observation on 12/01/25 at 9:25 A.M. of the walk-in freezer with DS #272 revealed a bag of cauliflower, a bag of hash brown patties, a box of hamburger patties and a bag of frozen chicken wings which had all been opened and were undated. DS #272 confirmed that the cauliflower, the hash brown patties, the hamburger patties and the chicken wings had been opened and were undated. DS #272 removed the identified undated food items from the freezer. Observation on 12/04/25 at 8:40 A.M. of the second floor kitchenette refrigerator with DS #272 revealed an unmarked, unidentified and undated bag of food. This was confirmed by DS #272. Observation on 12/04/25 at 8:47 A.M. of the third floor kitchenette refrigerator with DS #272 revealed two leftover containers that were unmarked, unidentified, and undated. Additionally, the refrigerator door would not close tightly due to an ice build-up in the freezer. DS #272 confirmed the two leftover containers that were unmarked, unidentified and undated as well as the ice build-up that prevented the refrigerator door from closing. Observation on 12/04/25 at 12:05 P.M. of the first-floor kitchenette refrigerator with DS #272 revealed three bags of unmarked, unidentified and undated food items along with one container of opened and undated cream cheese. DS #272 verified these items as described. Review of the policy titled, Food Receiving and Storage, revised July 2014, revealed food shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Food items and snacks kept on the nursing units in refrigerators must be labeled and dated (use by date), and all foods belonging to residents must be labeled with the resident's name, the item, and the use by date.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, staff interviews, and policy review, the facility failed to provide a homelike environment. This affected seven (#114, #47, #25, #50, #17, #71, and #73) out of seven residents reviewed for the environment. In addition, the facility failed to ensure the elevator was clean and had appropriate lighting. This had the potential to affect any resident who used the elevator. Additionally, the facility failed to ensure the memory care unit (MCU) was free from odors. This had the potential to affect all residents who resided in rooms 251, 252, 253, 254, 255, 256, 257, 258, and 259. The facility census was 111.Findings included:Observation of Resident #17's room on 12/01/25 at 11:12 A.M. revealed his tube feeding pole had a dried brownish substance running down the pole. His blind on the window was broken. The privacy curtain that was in the room had brown spots on it. Interview with the certified nursing assistant (CNA) #279 on 12/01/25 at 11:19 A.M. confirmed the tube feeding pole was dirty and had not been cleaned in some time. She confirmed the blind was broken and the curtain was dirty. Observation of #73's room on 12/01/25 at 11:23 A.M. revealed his blind was broken, and his privacy curtains had brown stains on them. Interview with the Housekeeping Aide #321 on 12/01/25 at 11:26 A.M. confirmed the blind was broken and the privacy curtain had brown stains on them.Observation of Resident #71's room on 12/01/25 at 11:27 A.M. revealed her privacy curtain was broken and hanging off the hooks in the ceiling. Observation of Resident #47's room on 12/02/25 at 11:30 A.M. revealed the curtains had a brown substance on them. Observation of Resident #25's room on 12/01/25 at 11:31 A.M. revealed the curtains on her windows had a yellowish brownish tint to them. The privacy curtain was off the track and was missing hooks.Observation on 12/01/25 at 11:59 A.M. of Resident #50's room revealed his privacy curtain was hanging halfway off the track.Interview with the Housekeeping Aide #321 on 12/01/25 at 12:00 P.M. confirmed Resident #71, #47, #25, and #50's privacy curtains needed cleaned or replaced. Observation of Resident #114's room on 12/01/25 at 11:45 A.M. revealed the walls coming into the room on the right-hand side had drops of a light brown substance running down them, there was a hole the size of a softball on the right side of the wall walking into the room and another hole on the left side of the wall walking into the room. Interview with the Maintenance Supervisor (MS) #211 on 12/01/25 at 11:45 A.M. confirmed holes in the walls needed to be fixed, confirmed the splashes running down the walls. Observation of the south elevator on 12/02/25 at 11:34 A.M. revealed there were stains on the floor and dirt in the corners. The lights were dim and the panels covering the lights had bugs and a black substance in them. There was one panel that was yellow in color. Interview with the Maintenance Assistant (MA) #229 on 12/01/25 at 11:40 A.M. confirmed the elevator was dim and dirty. Observation of the MCU on 12/03/25 at 1:04 P.M. revealed there was a pungent smell of urine and feces down the hall with room numbers 251, 252, 253, 254, 255, 256, 257, 258, and 259. Observation on 12/08/2025 at 11:20 A.M. revealed there was a pungent smell of urine and feces on the MCU down the same hall and in the same rooms as above. The Licensed Practical Nurse (LPN) #278 took spray and sprayed in the rooms and the hallway. She found a trash bag in a closet that looked like a wet blanket in it. Observation on 12/08/25 at 1:00 P.M. revealed there was a pungent smell of urine and feces on the MCU affecting the same hall and rooms. Interview with LPN #278 on 12/08/25 at 1:05 P.M. confirmed she didn't know what the smell was on the hall but would have to investigate it and call housekeeping. Review of the policy titled Homelike Environment dated 02/01/21 revealed residents will be provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.Policy Interpretation and ImplementationI. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment.b. comfortable (minimum glare) yet adequate (suitable to the task) lighting.c. inviting (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	colors and decor.d. comfortable and safe temperatures ande. comfortable sound levels.3. Comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and homelike environment. The lighting design emphasizes:a. sufficient general lighting in resident-use areas.b. task lighting as needed.c. reduction in glare (through use of light filters, no wax floors);d. even light levelsThis deficiency represents non-compliance investigated under Complaint Numbers 2661780, 2656231, 2655586, and 129629 (OH00162471).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366238	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwood Towers Post-Acute	1500 Sherman Avenue Cincinnati, OH 45212

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff and resident interviews and review of facility policy, the facility failed to provide privacy and dignity for three (Residents #39, #94, and #100) out of seven residents reviewed for dignity. The facility census was 111. Based on medical record review, observation, staff and resident interview and policy review, the facility failed to provide privacy and dignity for three (Residents #39, #94, and #100) out of seven residents reviewed for dignity. The facility census was 111. Findings Included: 1. Review of the medical record revealed Resident #39 was admitted to the facility on [DATE] with diagnoses of asthma, anorexia, major depressive disorder, and dementia. Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed that Resident #39 had moderate cognitive impairment and required setup and clean-up assistance for meals, partial to moderate assistance for bathing, and was dependent for toileting, personal hygiene, dressing upper and lower body, and placing shoes on and off feet. Review of the plan of care dated 10/01/25 revealed Resident #39 had an activity of daily living (ADL) self-care performance deficit related to dementia with behaviors, seizures, gout, arthritis, anxiety, and delusion. Interventions included left side of bed against wall for environmental enhancement, check nail length and trim and clean, provide sponge bath when a full bath or shower could not be tolerated, allow sufficient time for dressing and undressing, assist the resident to choose simple comfortable clothing that enhances the resident ability to dress self, encourage the resident to use bell to call for assistance, participate to the fullest extent possible with each interaction, and discuss with resident family or power of attorney any concerns related to loss of independent decline in function. Observation and interview on 12/01/25 at 2:54 P.M. with Resident #39 revealed Resident #39 had approximately a half inch of facial hair under her chin. Resident #39 stated it was not always there, and staff had taken care of it before. Resident #39 stated she would like staff to take care of the facial hair. Interview on 12/01/25 at 2:55 P.M. with Licensed Practical Nurse (LPN) #404 verified Resident #39 had facial hair under her chin. LPN #404 stated that the facial hair on Resident #39 chin was about a half inch long and was very noticeable. 2. Review of the medical record revealed Resident #94 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, diabetes mellitus type II and major depression. Review of the MDS Quarterly assessment dated [DATE] revealed that Resident #94 had severe cognitive impairment and required set up or clean-up assistance for meals. Review of the plan of care for Resident #94 dated 09/26/25 revealed that Resident #94 was at risk for ADL self-care performance deficit related to disease process, fatigue, pain, and stroke. Interventions were to keep nails trim and clipped, avoid scrubbing and pat dry sensitive skin during (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bathing, allow sufficient time for dressing and undressing, the resident required assistance by one staff to dress, and resident required weekly skin inspections. Observation on 12/01/25 at 9:41 A.M. revealed Resident #94 was sitting in the lounge area watching television dressed in a hospital gown, pants, and shoes. The hospital gown was thin and Resident #94 ' s breast could be seen through the gown. There were six (Residents #62, #58, #38, #5, #68, and #71) other residents in the immediate proximity of Resident #94 watching television. Interview on 12/10/25 at 9:42 A.M. with Certified Nursing Assistant (CNA) #279 verified that Resident #94 ' s breast could be seen through the hospital gown that was worn thin. CNA #279 revealed she did not know how long Resident #94 had been sitting in the main lounge area, because she just brought the residents who smoke back in from the smoke break. CNA #279 revealed Resident #94 had no clothes available and that she would replace the current hospital gown. 3. Review of the medical record revealed Resident #100 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type II, morbid obesity due to excess calories, cord compression, conductive hearing loss unilateral, and anxiety disorder. Review of the MDS admission assessment dated [DATE] revealed Resident #100 had intact cognition and required supervision or touching assistance for oral care, toileting, and personal hygiene, and substantial maximal assistance for bathing. Review of the plan of care for Resident #100 dated 10/23/25 revealed that Resident #100 was risk for ADL self-care performance deficit related to disease process, and musculoskeletal impairment. Interventions included check nail length and trim, resident required assistance of one to two staff members for showering, resident required assistance of one to two staff members to provide personal hygiene and encourage resident to participate to the fullest extent possible with interaction. Observation on 12/03/25 at 2:38 P.M. from the corridor outside of Resident #100 ' s room revealed the resident room door was wide open and allowed direct and unobstructed view by the Surveyor of Resident #100 laying in his bed. CNA #209 was observed applying deodorant to Resident #100 under the resident ' s arms. Resident #100 had a sheet that was folded down to the middle of his chest which left his chest exposed with no hospital gown on. Interview on 12/03/25 at 2:39 P.M. with CNA #209 revealed she had just provided Resident #100 a bed bath. CNA #209 revealed she opened the door after the bed bath was done to leave and Resident #100 called her back in the room to apply the deodorant. CNA #209 verified Resident #100 was exposed with the door open and this was a privacy issue. Interview on 12/03/25 at 2:40 P.M. with Resident #100 verified he was provided privacy, until the aid tried to leave, and he called her back in to his room to apply deodorant under his arms. Resident #100 verified that the door was open when he did have his deodorant applied by CNA #209, but it was not her fault. Resident #100 verified it would be a dignity issue if a person who knew him witnessed him exposed from the hallway. Review of the facility policy titled, Resident Rights, dated August 2009, revealed employees should treat all residents with kindness, respect, and dignity. Review of facility policy titled Activities of Daily Living-Supporting, dated 04/2025, revealed that the (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident is provided with care, treatment, and services to ensure their activities of daily living do not dimmish, unless the circumstances of their clinical condition (s) demonstrate diminishing activity of daily living are unavoidable. This deficiency represents non-compliance investigated under Complaint Number 1296290 (OH00162471) and 1296291 (OH00163286).

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to notify the physician, registered dietician, and resident's representative when Resident #24 had a change of condition. This affected one resident (#24) out of three residents reviewed for change of condition. The facility census was 111.Based on record review, staff interview, and policy review, the facility failed to notify the physician, the registered dietician, and the resident's representative when Resident #24 had a change of condition. This affected one resident (#24) out of three residents reviewed for change of condition. The facility census was 111.Findings include:Review of the medical record revealed Resident #24 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease with late onset, aphasia and protein-calorie malnutrition. Review of the Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #24 had severe cognitive impairment and was frequently incontinent of bowel and bladder. The resident required set up assistance for eating and oral hygiene, moderate assistance for toileting, bathing and transfers, maximal assistance for personal hygiene and dressing, and supervision for bed mobility. Review of the hospital documented weights for Resident #24 revealed on 02/18/25 Resident #24 weighed 151.7 pounds and on 08/08/25 Resident #24 weighed 160.5 pounds. Review of facility documented weights for Resident #24 revealed on 09/08/25 Resident #24 weighed 160.5 pounds and on 10/06/25 Resident #24 weighed 160 pounds. On 11/02/25 Resident #24 had a documented weight of 145.2 pounds and on 11/05/25 Resident #24 had a documented weight of 143.6 pounds. This represented a weight loss of 10.25 percent in one month, from 10/06/25 to 11/05/25. Review of a nursing progress note for Resident #24 dated 12/03/25 at 3:16 P.M. authored by Assistant Director of Nursing (ADON) #224 revealed ADON #224 called Resident #24's representative to discuss the resident's severe weight loss. The resident's representative requested to be kept updated and asked for any recommendations or suggestions to improve the resident's nutritional status. A telephone interview on 12/03/25 at 2:24 P.M. with Registered Dietician #600 verified she was not aware of Resident #24's severe weight loss of 10.25 percent on 11/02/25 until 11/10/25 when she was in the facility reviewing weekly weights. Interview on 12/03/25 at 3:17 P.M. with ADON #224 verified Resident #24's representative was not notified of the resident's severe weight loss on 11/02/25 until 12/03/25. Interview on 12/04/25 at 11:29 A.M. with the Director of Nursing verified the delay in notification to the physician, dietician and resident representative about Resident #24's severe weight loss. A telephone interview on 12/04/25 at 1:21 P.M. with Medical Director #900 verified the facility did not make notification to her of Resident #24's 11/02/25 severe weight loss until 11/10/25. Review of the policy titled, Weight Assessment and Intervention, revised in March 2022, revealed a one-month weight loss of 5 percent is significant, and greater than 5 percent is severe.Review of the policy titled, Change in a Resident's Condition or Status, revised May 2017, revealed a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, Minimum Data Set (MDS) review, staff interview, review of the Resident Assessment Instrument (RAI) manual, and policy review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) was completed when a resident received a new diagnosis of bipolar disorder and when a resident had a severe weight loss. This affected two (Residents #3 and #24) of three residents reviewed for a significant change in condition. The facility census he was 111.Based on medical record review, staff interview, review of the Resident Assessment Instrument (RAI) manual, and policy review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) was completed when a resident received a new diagnosis of bipolar disorder and when a resident had a severe weight loss. This affected two (Residents #3 and #24) of three residents reviewed for a significant change in condition. The facility census he was 111. Findings include: 1. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses of Guillain Barre Syndrome, abnormalities of gait and mobility, long term drug therapy, obesity, asthma, malnutrition, respiratory failure, pulmonary edema, spinal stenosis, gastrostomy tube, depression, edema, and diabetes. A diagnosis of bipolar disorder was added 08/19/24. Review of the medical record for Resident #3 revealed Resident #3 was seen by the psychiatric services provider on 08/09/24 who diagnosed Resident #3 with bipolar disorder. Review of Minimum Data Set (MDS) assessments for Resident #3 revealed a Significant Change assessment had not been completed for Resident #3 that reflected the new diagnosis of bipolar disorder. 2. Review of the medical record revealed Resident #24 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease with late onset, aphasia and protein-calorie malnutrition. Review of the MDS admission assessment dated [DATE] revealed Resident #24 had severe cognitive impairment and was frequently incontinent of bowel and bladder. The resident required set up assistance for eating and oral hygiene, moderate assistance for toileting, bathing and transfers, maximal assistance for personal hygiene and dressing, and supervision for bed mobility. Review of the hospital documented weights for Resident #24 revealed on 02/18/25 Resident #24 weighed 151.7 pounds and on 08/08/25 Resident #24 weighed 160.5 pounds. Review of facility documented weights for Resident #24 revealed on 09/08/25 Resident #24 weighed 160.5 pounds and on 10/06/25 Resident #24 weighed 160 pounds. On 11/02/25 Resident #24 had a documented weight of 145.2 pounds and on 11/05/25 Resident #24 had a documented weight of 143.6 pounds. This represented a weight loss of 10.25% in one month, from 10/06/25 to 11/05/25. Review of the MDS assessments for Resident #24 revealed a Significant Change assessment had not been completed for Resident #24 that reflected the severe weight loss. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/15/25 at 4:47 P.M. with the MDS Director #258 verified the MDS Significant Change of Status assessments had not been completed for Resident #3 after the new diagnosis of bipolar disorder or for Resident #24 after his severe weight loss but should have been completed within 14 days of the change of conditions for both Residents #3 and #24 Review of the facility policy titled Resident Assessments, dated October 2023, revealed residents with a significant change of status must undergo a comprehensive assessment which includes the Minimum Data Set (MDS) assessment, Care Area Assessment (CAA) process and care planning. Review of the Resident Assessment Instrument (RAI) manual revealed that once a change of status is determined to have occurred the comprehensive assessment process must be completed within fourteen (14) days.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure residents with newly evident or possible serious mental disorders were referred for level II resident review upon a significant change in status assessment. This affected one (Resident #3) of four residents reviewed for pre-admission screening and resident review (PASARR). The facility census was 111.Based on record review and staff interview, the facility failed to ensure residents with newly evident or possible serious mental disorders were referred for level II resident review upon a significant change in status assessment. This affected one (Resident #3) of four residents reviewed for pre-admission screening and resident review (PASARR). The facility census was 111.Findings include: Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses of Guillain Barre Syndrome, abnormalities of gait and mobility, long term drug therapy, obesity, asthma, malnutrition, respiratory failure, pulmonary edema, spinal stenosis, hypertension, gastrostomy tube, depression, edema, and diabetes mellitus type II.Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #3 had intact cognition and was always continent of bowel and occasionally incontinent of bladder. The resident required supervision for eating and oral hygiene, maximal assistance for personal hygiene, toileting, dressing, and bed mobility, and was dependent for bathing and transfers.Review of the medical record for Resident #3 revealed Resident #3 was assessed by the psychiatric services provider Nurse Practitioner on 08/09/24 who gave Resident #3 a new diagnosis of bipolar disorder. Interview on 12/09/25 at 2:33 P.M. with the Director of Nursing verified Resident #3, on 08/09/24, had been assigned a new diagnosis of bipolar disorder and that a new PASARR and comprehensive assessment had not been completed or referred for a level II resident review.Interview on 12/15/25 at 11:39 A.M. with Social Service Assistant (SSA) #232 revealed she does all resident change of status PASARR's. SSA #232 revealed she relied on the psychiatric services provider to alert her when a resident was assigned a new mental health diagnosis. SSA #232 verified she was not notified of Resident #3's assigned diagnosis of bipolar disorder and a new PASARR was not completed or referred for level II resident review. Review of the facility policy titled, Change in a Resident's condition or Status, revised May 2017, revealed when a resident has a significant change in mental status, the resident's representative (with resident's approval) will be notified of change as well as the state mental health agency within twenty-four (24) hours.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, Pre-admission Screening and Resident Review (PASARR) review, staff interviews, and policy review, the facility failed to make notification to the state mental health agency for a significant change in mental health diagnosis for one (Resident #3) of three residents reviewed for notification of change process. The facility census was 111.Based on medical record review, Pre-admission Screening and Resident Review (PASARR) review, staff interviews, and policy review, the facility failed to make notification to the state mental health agency for a significant change in mental health diagnosis for one (Resident #3) of three residents reviewed for notification of change process. The facility census was 111.Findings include:Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses of Guillain Barre Syndrome, abnormalities of gait and mobility, long term drug therapy, obesity, asthma, malnutrition, respiratory failure, pulmonary edema, spinal stenosis, hypertension, gastrostomy tube, depression, edema, and diabetes mellitus type II.Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #3 had intact cognition and was always continent of bowel and occasionally incontinent of bladder. The resident required supervision for eating and oral hygiene, maximal assistance for personal hygiene, toileting, dressing, and bed mobility, and was dependent for bathing and transfers.Review of PASARR for Resident #3 dated 02/01/24 revealed Resident #3 had diagnosis of serious mental illness (SMI). Interview on 12/09/25 at 2:33 P.M. with the Director of Nursing verified Resident #3, on 08/09/25, had been assigned a new diagnosis of bipolar disorder and that a new PASARR and comprehensive assessment had not been completed or referred for a level II resident review.Interview on 12/15/25 at 11:39 A.M. with Social Service Assistant (SSA) #232 revealed she does all resident change of status PASARR's. SSA #232 revealed she relied on the psychiatric services provider to alert her when a resident was assigned a new mental health diagnosis. SSA #232 verified she was not notified of Resident #3's assigned diagnosis of bipolar disorder and a new PASARR was not completed or referred for level II resident review. Review of facility policy titled Change in a Resident's condition or Status revised May 2017, revealed when a resident has a significant change in mental status, resident's representative (with resident's approval), will be notified of change as well as the state mental health agency within 24 hours.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, resident interview, and policy review, the facility failed to ensure residents were provided with necessary assistance for Activities of Daily Living (ADL's). This affected three (Residents #17, #73 and #76) of five residents reviewed for ADL's. The facility census was 111. Based on medical record review, staff interview, resident interview, observation, and policy review, the facility failed to ensure residents were provided with necessary assistance for Activities of Daily Living (ADL's). This affected three (Residents #17, #73 and #76) of five residents reviewed for ADL's. The facility census was 111. Findings included: 1.Medical record review for Resident #17 revealed an admission date of 08/13/24. Medical diagnoses included diabetes, cerebrovascular attack, dysphagia, cognitive communication deficit, and gastrostomy. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #17 was severely cognitively impaired. Functional status revealed eating was not applicable, dependent for toileting, bed mobility and transfers. He was frequently incontinent for bowel and bladder. Review of the care plan dated 11/05/25 revealed Resident #17 has an ADL self-care performance deficit related to activity intolerance. The resident required assistance from two staff members with bathing/showering to be given twice weekly and as necessary.Observation on 12/01/25 at 11:12 A.M. revealed the resident was lying in bed. His feet had a thick coating of a yellow substance, and his mattress had flakes of a yellow substance and a white film on it. Interview with Certified Nursing Aide (CNA) #279 on 12/01/25 at 11:19 A.M. confirmed his feet were encrusted with yellow substance and his mattress was dirty. 2. Medical record review for Resident #73 revealed an admission date of 02/08/25. His medical diagnoses included diabetes, cancer, viral hepatitis, and hypertension. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #73 was cognitively intact. His functional status was for bathing was supervision or touching assistance for mobility and setup or clean-up assistance for bathing. Review of the shower documentation for Resident #73 dated from 11/04/25 through 12/02/25 revealed out of nine opportunities he received one on 11/04, 11/11, 11/18, 11/21, and 12/02/25. He refused on 11/25/25 and on 11/07, 11/14, 11/17, and 11/28 the bathing was documented as non-applicable. Interview with CNA #283 on 12/08/25 at 9:13 A.M. revealed the residents were supposed to receive two bathing experiences a week and stated they should be documented on the tasks button under was shower given. She confirmed Resident #73 did not receive the bathing twice a week. 3. Review of the medical record revealed Resident #76 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation, diabetes mellitus type II, protein-calorie malnutrition, malignant neoplasm of prostate, uropathy of bladder and hypertension. Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #76 had intact cognition and was occasionally incontinent of bowel and had a catheter for the bladder. The resident required supervision for eating, oral and personal hygiene, toileting, dressing and transfers, moderate assistance for bathing, and was independent for bed mobility. Review of the plan of care for Resident #76's last reviewed 07/07/25 revealed Resident #76 had an ADL self-care deficit related to his disease process, fatigue, musculoskeletal impairment and cancer. The resident required assistance from one staff with bathing/showering twice weekly and as necessary. Interview on 12/09/25 at 1:50 P.M. with Resident #76 revealed resident was doing his own showers every other day without any staff assistance. Resident #76 revealed he had worked with therapy to get his strength back to be able to do his own showers. Resident #76 revealed when he first arrived at the facility, he received no regular bathing. He revealed he was not sure what his bathing schedule was then and was still not certain what days he was to get assistance with showers. Interview on 12/10/25 at 2:12 P.M. with a family member (who did not want to be identified) revealed concerns about the lack of bathing of Resident #76. They expressed concern initially as Resident #76 was too weak to bathe on his own. The family member revealed they now believed Resident #76 could do some of his own bathing but should still be (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervised. Review of shower documentation for Resident #76 revealed he was to be assisted with bathing on Mondays and Thursdays during dayshift (7:00 A.M. to 7:00 P.M.). Review of shower sheets for Resident #76 dated from 07/19/25 to 12/10/25 revealed resident #76 was not scheduled for any showers from 07/26/25 to 08/10/25, 08/26/25 to 09/05/25, and 10/07/25 to 10/17/25. Review of policy titled Activities of Daily Living revealed residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. This deficiency represents non-compliance investigated under Complaint Numbers 2685204, 2656231, 2594798, and 1296294 (OH00165918).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366238	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwood Towers Post-Acute	1500 Sherman Avenue Cincinnati, OH 45212

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, staff and resident interviews, and policy review, the facility failed to ensure residents were safely smoking on the facility property. This affected two (#47 and #103) of two residents reviewed for smoking. The facility identified there were fifteen residents who required assistance with smoking. The facility census was 111. Findings include: 1. Review of the medical record for Resident #103 who revealed an admission date 08/09/22. Diagnoses included mood affective disorder, major depressive disorder, anxiety disorder, bipolar disorder, and prediabetes. Review of the smoking observation and assessment dated [DATE] revealed Resident #103 had smoking device use was cigarettes, was cognitive impaired, and had visual impairment. Resident #103 had dexterity impairments. Resident #103 can light his own smoking device. Smoking adaptive equipment needed was smoking apron. Level of assistance during smoking revealed supervision was required. Review of the plan of care dated 08/09/22 revealed Resident #103 was a supervised smoker, and may only go out during supervised smoking times. Interventions included to assist to and from the smoking area as needed, ensure smoking materials was extinguished before entering the building, explain facility smoking policy to the resident, observe resident for unsafe behaviors and attempt to obtain smoking material from outside sources, provide smoking assistive device as needed, reassess smoking safety quarterly, annual, and with significant change, and remove oxygen before taking resident out to smoke. Observation on 12/01/25 at 9:52 A.M. revealed Resident #103 was dressed in his room. He was sitting in his wheelchair. Resident #103 had three burns on his grey sweatshirt with a skeleton on it. Interview on 12/01/25 at 9:52 A.M. with Resident #103 stated he had no concerns at the facility and was waiting for his smoke break. Observation on 12/04/25 at 1:32 P.M. revealed Resident #103 did not have a smoking apron on during the 1:30 P.M. smoking break. 2. Review of the medical record for Resident #47 revealed an admission date 11/26/21. Diagnoses included chronic obstructive pulmonary disease, major depressive disorder, legal blindness, and osteoporosis. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was cognitively impaired. Resident #47 required supervision or touching assistance for meals and was dependent on staff for dressing upper and lower body. Review of the plan of care dated 09/23/24 revealed Resident #47 was a supervised smoker and may only go out during supervised smoking times. Interventions included assisting to and from the smoking area as needed, ensure smoking material was extinguished before entering the building, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	explain facility smoking policy to resident and family, provide smoking assistive devices as needed, remove oxygen before taking resident out to smoke, smoking apron to be worn at all smoke breaks, and store smoking material in safe place. Observation on 12/01/25 at 1:30 P.M. revealed Resident #47 was smoking at the designated 1:30 P.M. smoke break time. There were no residents who were smoking with a smoking apron on, including Resident #47. At 1:34 P.M., Resident #47 went inside the facility after smoking. Resident #47 was never offered a smoke apron for protection. Interview on 12/01/25 at 1:37 P.M. with Certified Nursing Assistant (CNA) #279 verified Resident #47 did not have a smoking apron on and did smoke with her supervising her. CNA #279 stated she did not know that Resident #47 required a smoking apron. Review of the facility policy titled Smoking Policy – Residents, revised July 2017, revealed the facility shall establish and maintain safe resident smoking practices. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include: a. current level of tobacco consumption; b. method of tobacco consumption; c. desire to quit smoking, if a current smoker; d. ability to smoke safely with or without supervision. Any smoking-related privileges, restrictions, and concerns shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident and staff interviews, and review of the facility policy, the facility failed to ensure the resident's medications were properly stored. This affected one (Resident #100) of 37 residents reviewed for medication storage. The facility census was 111.Findings include: Medical record review revealed Resident #100 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #100 had intact cognition. The medical record, including physician orders, assessments, and plan of care, revealed Resident #100 had not been assessed or approved for self-administration of medications. Observation and interview on 12/02/25 at 9:42 A.M. with Resident #100 revealed a plastic cup containing various colored medications sitting in front of Resident #100 on the overbed table along with a cup of water. There was no labeling on the cup with the various colored medications. Resident #100 revealed he often consumed the medications unsupervised and unwitnessed. There were ten unnamed medications in the plastic medicine cup. Interview on 12/02/25 at 9:44 A.M. with Medication Aide #265 confirmed she left a cup full of medications on the table in front of Resident #100. Medication Aide #265 verified no knowledge of Resident #100's self-administration of medication status. Interview on 12/03/25 at 9:27 A.M. with Licensed Practical Nurse (LPN) #278 verified medication(s) should never be left unattended at the bedside. She said the nurse or medication technician must observe the resident taking the medication(s). Interview on 12/08/25 at 11:46 A.M. with the Director of Nursing (DON) revealed the facility had no residents approved to self-administer medications. Review of the policy titled Administering Medications revised April 2019 revealed for residents not in their rooms or otherwise unavailable to receive medication on the pass, the Medication Administration Record (MAR) may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication Review of the facility policy titled Storage of Medications, revised November 2020, revealed the facility should store all drugs and biologicals in a safe, secure, and orderly manner.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and facility policy review, the facility failed to ensure the call light was within reach for three (#22, #39, and #84) out of 25 residents reviewed. The facility census was 111. Findings Included: 1. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, seizures, epilepsy, hemiplegia, and dementia. Review of Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed that Resident #22 had severe cognitive impairment and required setup or clean-up assistance for eating, oral care, bathing, dressing upper body, dressing lower body, putting on and off feet, and personal hygiene. Review of the plan of care for Resident #22 dated 10/20/25 revealed Resident #22 was at risk for activity of daily living self-care performance deficit and required staff supervision for ambulation, assist one person for morning and evening care, encouraged to participate in care to promote independent, monitor decline, and resident prefers long nails. Resident #22 was also at risk for falls related to cardiac conditions, dementia, diuretic use, and impaired safety awareness. Interventions included call light in reach while in the room and fall risk assessment per policy to evaluate risk for falls. Observation on 12/01/25 at 9:46 A.M. revealed Resident #22's call light was not in reach. Resident #22's call light was attached to a box located on the wall, next to the bedside table light above the bed. Resident #22 was unable to reach his call light which was approximately four feet away from the resident. Interview on 12/01/25 at 9:47 A.M. with Licensed Practical Nurse (LPN) #253 verified that Resident #22 could not reach his call light that was pinned on wall next to the overbed light. 2. Review of the medical record revealed Resident #39 was admitted to the facility on [DATE] with diagnoses of asthma, anorexia, major depressive disorder, and dementia. Review of MDS Quarterly assessment dated [DATE] revealed that Resident #39 moderate cognitive impairment and required set-up and clean-up assistance for meals, partial to moderate assistance for bathing, and was dependent on toileting, personal hygiene, dressing upper and lower body, and placing shoes on and off feet. Review of plan of care for Resident #39 dated 10/01/25 revealed that Resident #39 was at risk for activity of daily living self-care performance deficit related to dementia with behaviors, seizures, gout, arthritis, anxiety, and delusions. Interventions included left side bed against the wall, assist the resident to choose simple comfortable clothing that enhances the resident's ability to dress self, make sure shoes are comfortable, resident required extensive assistance by one staff with personal hygiene and oral care. Observation on 12/01/25 at 9:58 A.M. with Resident #39 who was in her bed, and her call light was wrapped around the left upper wheel under the bed. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/01/25 at 9:58 A.M. with LPN #253 who verified that Resident #39 could not get her call light because it was under the bed. 3. Review of the medical record revealed Resident #84 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type two, anxiety, and major depression. Review of the MDS Quarterly assessment dated [DATE] revealed that Resident #84 had moderate cognitive impairment and required partial to moderate assistance for toileting, and personal hygiene. Review of plan of care for Resident #84 dated 12/02/25 revealed Resident #84 was at risk for activity of daily living self-care performance deficit related to activity intolerance, confusion, disease process, fatigue, and impaired balance. Interventions included encouraging the resident to use bell to call for assistance, encourage the resident to discuss feelings about self-care, and resident required assistance by one staff for toileting, transfers, and personal hygiene. Observation on 12/01/25 at 9:59 A.M. with Resident #84 who was lying in bed, and call light was wrapped under the left top wheel under the bed.Interview on 12/01/25 at 10/01/25 with LPN #404 who verified the call light was tangled under the bed, and the resident could not reach the call light for assistance. Review of the facility policy titled Answering the Call Light dated 10/2010 revealed the purpose of this procedure was to respond to the resident's requests and needs.